

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0044974</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Douglas Care & Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>PO Box 978, W. Rt. 121</u> <u>Mattoon</u> <u>61938</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Coles</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Alan Zampini</u> (Title) <u>Chief Executive Officer</u>	
Telephone Number: <u>217-234-6401</u> Fax # <u>217-258-3300</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>36-4379322</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>7/15/00</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles Smith</u> Telephone Number: <u>505-366-5211</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Douglas Care & Rehab Center# 0044974 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>79</u>	Skilled (SNF)	<u>79</u>		1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>		7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,132</u>	<u>3,814</u>	<u>3,676</u>	<u>23,622</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,132</u>	<u>3,814</u>	<u>3,676</u>	<u>23,622</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.66%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/15/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 7/15/00NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 16and days of care provided 3,054Medicare Intermediary TRAILBLAZERS

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/01Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Douglas Care & Rehab Center # 0044974 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	106,619	9,552	6,251	122,422		122,422		122,422			1
2	Food Purchase		95,556		95,556		95,556		95,556			2
3	Housekeeping	48,132	10,240	22	58,394		58,394		58,394			3
4	Laundry	26,968	9,932	404	37,304		37,304		37,304			4
5	Heat and Other Utilities			83,964	83,964		83,964		83,964			5
6	Maintenance	27,043	2,691	22,851	52,585		52,585		52,585			6
7	Other (specify):*											7
8	TOTAL General Services	208,762	127,971	113,492	450,225		450,225		450,225			8
	B. Health Care and Programs											
9	Medical Director			1,065	1,065		1,065		1,065			9
10	Nursing and Medical Records	889,517	36,146	1,867	927,530		927,530	4,147	931,677			10
10a	Therapy	36,906	18,861	123,853	179,620		179,620	11,743	191,363			10a
11	Activities	39,521	5,082	2,228	46,831		46,831		46,831			11
12	Social Services	26,668	479	2,003	29,150		29,150		29,150			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	992,612	60,568	131,016	1,184,196		1,184,196	15,890	1,200,086			16
	C. General Administration											
17	Administrative	59,159			59,159		59,159		59,159			17
18	Directors Fees											18
19	Professional Services			60,957	60,957		60,957	(4,121)	56,836			19
20	Dues, Fees, Subscriptions & Promotions			232,234	232,234	(2,529)	229,705	(220,350)	9,355			20
21	Clerical & General Office Expenses	90,362	14,015	86,072	190,449		190,449	50,872	241,321			21
22	Employee Benefits & Payroll Taxes			275,119	275,119		275,119	13,447	288,566			22
23	Inservice Training & Education			1,191	1,191		1,191	396	1,587			23
24	Travel and Seminar							17,617	17,617			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,211	98,211		98,211	1,608	99,819			26
27	Other (specify):*			6,635	6,635		6,635		6,635			27
28	TOTAL General Administration	149,521	14,015	760,419	923,955	(2,529)	921,426	(140,531)	780,895			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,350,895	202,554	1,004,927	2,558,376	(2,529)	2,555,847	(124,641)	2,431,206			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **Douglas Care & Rehab Center**

#0044974

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,316	3,316		3,316	53,203	56,519			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,234	7,234		7,234	21,810	29,044			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			503,949	503,949		503,949	16,283	520,232			34
35	Rent-Equipment & Vehicles			4,712	4,712		4,712	2,708	7,420			35
36	Other (specify):*			49,706	49,706		49,706		49,706			36
37	TOTAL Ownership			568,917	568,917		568,917	94,004	662,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			569	569		569		569			38
39	Ancillary Service Centers			193,851	193,851		193,851		193,851			39
40	Barber and Beauty Shops			43,241	43,241		43,241		43,241			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			237,661	237,661		237,661		237,661			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,350,895	202,554	1,811,505	3,364,954	(2,529)	3,362,425	(30,637)	3,331,788			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Douglas Care & Rehab Center# 0044974Report Period Beginning: 01/01/01Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,149)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,858)	21		24
25	Fund Raising, Advertising and Promotional	(4,303)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,310)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (47,310)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Douglas Care & Rehab Center

ID# 0044974

Report Period Beginning: 01/01/01

Ending: 12/31/01

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Management Fees-Related Party	\$ (216,004)	20	1
2	Resident Settlements	(10,000)	21	2
3	Cash over/short	(107)	21	3
4	Accounting/Audit Fee Accruals	(4,500)	19	4
5	Adjustment to Related Party Lease Cost	13,116	34	5
6	Interest Expense	(7,235)	32	6
7	Adjust Depreciation to Straight Line including	43,082	30	7
8	prior owner purchases			8
9	Clinical salaries - Central office	4,147	10	9
10	Therapy - central office	11,743	10a	10
11	Professionals services - central office	12,528	19	11
12	Dues, fees, etc - central office	875	20	12
13	Clerical & general - central office	91,837	21	13
14	Employee Benefits	13,447	22	14
15	Inservice & education	396	23	15
16	Travel & seminar	17,617	24	16
17	Insurance Prop Liability Malpractice	1,608	26	17
18	Depreciation	10,121	30	18
19	Interest	29,045	32	19
20	Real estate taxes	0	33	20
21	Rent-facility & grounds	3,167	34	21
22	Rent-equipment & vehicle	2,708	35	22
23	Late Fees	(567)	20	23
24	Bank Fees	(351)	20	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	16,673		49

Summary A

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business NF
		Per state, deemed not related party				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	We sub-lease from related party, however, our sublessor leases from un-related Party		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$		\$	\$ *		14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Douglas Care & Rehab Center # 0044974 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Douglas Care & Rehab Center # 0044974 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Ballantrae Healthcare, LLC
 Street Address 1128 Pennsylvania NE Suite 100
 City / State / Zip Code Albuquerque, NM 87110
 Phone Number (505-366-5200
 Fax Number (505-366-5283

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Attachment 8.1 for Central Office Allocation				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Douglas Care & Rehab Center**# **0044974** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 26,230	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 19,822	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,408)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 44,770	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 38,362	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 39,345 8	FOR OHF USE ONLY	
	1997 41,846 9		
	1998 39,385 10	13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
	1999 57,868 11		
	2000 43,249 12	14 PLUS APPEAL COST FROM LINE 5 \$	14
Real Estate Tax Accrual taken from Financials recorded based on amount put into property tax escrow account			
NOTE: Ballantrae took over operation of Douglas on 7/15/2000. The total taxes paid for tax year 2000 were 43,249.		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Douglas Care & Rehab Center COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0044974

CONTACT PERSON REGARDING THIS REPORT Charles Smith

TELEPHONE 505-366-5211 FAX #: 505-366-5283

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-1-00300-000</u>	<u>PT of SEC 10 BK701 PG188</u>	\$ <u>40,712.00</u>	\$ <u>40,712.00</u>
2. <u>07-1-00300-001</u>	<u>PT of SEC 10 BK701 PG188</u>	\$ <u>2,194.00</u>	\$ <u>2,194.00</u>
3. <u>07-1-00572-000</u>	<u>PT of SEC 10 BK701 PG188</u>	\$ <u>343.00</u>	\$ <u>343.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>43,249.00</u></u>	\$ <u><u>43,249.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

30,837

B.

General Construction Type:

Exterior

BRICK

Frame

METAL STUDS/PLAS

Number of Stories

1

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Douglas Care & Rehab Center

STATE OF ILLINOIS

0044974

Report Period Beginning:

01/01/01

Ending:

Page 12A

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 521,412	\$	\$ 46,398	\$ 46,398	Various	\$ 252,814	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Purchased Prior Years/Door Hinges	8,610		1,722	1,722	5	2,070	74
75	TOTALS	\$ 530,022	\$	\$ 48,120	\$ 48,120		\$ 254,884	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 530,022	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,120	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,120	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 254,884	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>	<u>79</u>	<u>7/15/00</u>	\$ <u>503,949</u>	<u>6</u>	<u>5</u>	3
4	Additions							4
5	<u>Adj to Lease Expense to Recorded on Financials</u>				<u>13,116</u>			5
6								6
7	TOTAL		<u>79</u>		\$ <u>517,065</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 7/15/00

Ending 1/31/06

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ 541,944

13. /2003 \$ 552,780

14. /2004 \$ 462,959

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		44 hrs	\$ 1,668		
2	Licensed Speech and Language Development Therapist		43 hrs	1,237					43	1,237	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		81 hrs	2,836					81	2,836	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL			\$ 5,741		\$	\$		168	\$ 5,741	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (706,488)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	227,058		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(1,961)		6
7	Other Prepaid Expenses	42,286		7
8	Accounts Receivable (owners or related parties)	242,564		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (196,541)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	12,921		15
16	Equipment, at Historical Cost	17,418		16
17	Accumulated Depreciation (book methods)	(3,316)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	110,708		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 137,731	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (58,810)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (1,411)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	86,817		29
30	Accrued Salaries Payable	(9,770)		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,025		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,052		32
33	Accrued Interest Payable	11,576		33
34	Deferred Compensation	(2,899)		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		156,292		36
37		92,733		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 379,415	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		79,055		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 79,055	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 458,470	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (289,480)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 168,990	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(233,867)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (233,867)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (233,867)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,177,331	1
2	Discounts and Allowances for all Levels	759,833	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,937,164	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,407	6
7	Oxygen	20,053	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,460	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	132	13
14	Non-Patient Meals	237	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,731	19
20	Radiology and X-Ray	37	20
21	Other Medical Services	33,757	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 66,894	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,130,518	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	450,225	31
32	Health Care	1,184,196	32
33	General Administration	923,955	33
	B. Capital Expense		
34	Ownership	568,917	34
	C. Ancillary Expense		
35	Special Cost Centers	237,092	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,364,385	40
41	Income before Income Taxes (line 30 minus line 40)**	(233,867)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (233,867)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Douglas Care & Rehab Center**# **0044974**Report Period Beginning: **01/01/01**

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,080	\$ 53,510	\$ 25.73	1
2	Assistant Director of Nursing	1,776	1,920	38,676	20.14	2
3	Registered Nurses	11,915	12,486	228,846	18.33	3
4	Licensed Practical Nurses	10,156	10,661	159,334	14.95	4
5	Nurse Aides & Orderlies	39,288	41,302	385,538	9.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	159	167	5,740	34.37	7
8	Rehab/Therapy Aides	1,589	1,815	35,298	19.45	8
9	Activity Director	2,005	2,151	22,985	10.69	9
10	Activity Assistants	4,093	4,375	41,207	9.42	10
11	Social Service Workers	1,948	1,990	26,862	13.50	11
12	Dietician					12
13	Food Service Supervisor	1,828	1,920	32,979	17.18	13
14	Head Cook	7,402	7,785	57,621	7.40	14
15	Cook Helpers/Assistants	3,303	3,357	22,339	6.65	15
16	Dishwashers					16
17	Maintenance Workers	2,009	2,216	28,210	12.73	17
18	Housekeepers	7,122	7,577	51,836	6.84	18
19	Laundry	4,099	4,292	28,492	6.64	19
20	Administrator	1,968	2,080	59,610	28.66	20
21	Assistant Administrator	152	160	3,616	22.60	21
22	Other Administrative					22
23	Office Manager	2,094	2,212	37,603	17.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,290	1,467	20,468	13.95	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,132	112,013	\$ 1,340,770 *	\$ 11.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	178	\$ 5,531	line 1 col 3	35
36	Medical Director	12	1,065	line 9 col 3	36
37	Medical Records Consultant	8	230	line 10 col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,185	line 10 col 3	39
40	Physical Therapy Consultant		68,596	line 10a col 3	40
41	Occupational Therapy Consultant		52,944	line 10a col 3	41
42	Respiratory Therapy Consultant		50	line 10a col 3	42
43	Speech Therapy Consultant		2,263	line 10a col 3	43
44	Activity Consultant	48	2,228	line 11 col 3	44
45	Social Service Consultant	40	2,003	line 12 col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	\$ 139,095		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Douglas Care & Rehab Center

0044974

Report Period Beginning: 01/01/01

Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description		Description		Description			
Teresa Crawford	Administrator	none	\$ 59,610	Workers' Compensation Insurance	\$ 48,306	IDPH License Fee	\$ 200				
				Unemployment Compensation Insurance	13,946	Advertising: Employee Recruitment	6,869				
				FICA Taxes	102,020	Health Care Worker Background Check					
				Employee Health Insurance	104,649	(Indicate # of checks performed)					
				Employee Meals		HCFA Lab Program - CLIA User Fee	150				
				Illinois Municipal Retirement Fund (IMRF)*		Jesse White Sec of State -Assumed Name Ap	285				
				Employee Relations	584	Corporation Services Company	395				
				Local PR Tax	1,422	MO Sec of State - LLC Annual Report	200				
				Employee Benefits Other	4,192	See Attachment 21.1	3,261				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 59,610							
B. Administrative - Other											
Description				Amount							
				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$							
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount		Description	Amount		
SHS. Com	MIS Software Support		\$ 18,708			\$		Out-of-State Travel	\$ 17,617		
KRONOS	Payroll System Support		388					Refer to Central Office Attachment			
IVANS	Medicare System		1,032								
AT&T	Computer Line Fees		6,622					In-State Travel			
MDI Technologies	A/R System Support		4,150								
Alliance	Payroll Processing		3,192								
TBT/IL DEPT Employment Secr	Unemployment Tax Consult		2,228								
Jay Boynton Architecture	Architect		2,863					Seminar Expense			
Near North Insur Brokerage	Surety Bonds		620								
See Attachment 21.1			21,154								
TOTAL (agree to Schedule V, line 19, column 3)						\$		Entertainment Expense	()		
(If total legal fees exceed \$2500 attach copy of invoices.)				\$ 60,957				(agree to Sch. V,			
								line 24, col. 8)	\$ 17,617		

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL Health Care Assoc. \$316
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,241
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: Not performed before filing report The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.